your health
NETWORK
A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS
July 2008 Volume 16, Number 1

inside

Protecting Your Health Information

Keeping our personal health information secure and confidential is important to all of us. Privacy regulations required by the Federal Health Insurance Portability and Accountability Act (HIPAA) place certain requirements on how your private health information (PHI) is handled by healthcare providers and health plans. These standards provide patients more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

The state group insurance program's *Notice of Privacy Practices* describes your rights under the law and how Benefits Administration, as well as our plan administrators (BlueCross BlueShield of Tennessee, United Healthcare and Cigna Healthcare) must protect your private health information from disclosure to unauthorized individuals. These same regulations apply to your physician and hospital, as well as other healthcare providers where you may seek care.

For example, your private health information may be used and disclosed for:

- Your treatment
- Payment of claims
- Healthcare operations
- Communication
- In response to a court order

HIPAA privacy rules also provide certain individual rights to you, such as the right to:

- Inspect and copy your information
- Restrict use of your PHI
- Make a written request to amend your PHI

Due to our privacy practices, when you call our office or the plan administrator you will be asked to verify your identity. If a personal representative of yours calls (such as your spouse) we will request certain identifying information before we can release any information to the caller, such as the ID number on your insurance card, your social security number, date of birth or other identifying information. This is all done to protect your health information. If the required information cannot be provided, we cannot release information to the caller.

Your health is important to us, and so is your privacy. If you would like a copy of our complete HIPAA privacy policy, please call our customer service center at 1.800.253.9981 or you may view the notice on our website — just click on the "publications and forms" link.

Dependent Eligibility Audit

Benefits Administration is currently in the planning phase for a dependent eligibility audit. In January 2009, all participants with dependent coverage will be asked to provide documentation verifying the eligibility of all covered dependents. Policy holders will be provided with a list of their covered dependents, a worksheet to assist in determining the eligibility status of their dependents and a list of appropriate documentation which may be provided to establish eligibility by dependent category. In addition, we will begin requiring documentation regarding the eligibility for all new dependents being enrolled once the audit begins.

Increasing healthcare costs, rising premiums and an increased emphasis on oversight and accountability have highlighted the need for the division to provide assurance that health coverage on the public sector plans is provided only to members and their eligible dependents in accordance with plan eligibility guidelines.

Increasingly, employers are engaged in looking critically at benefit structures, plan costs and identifying opportunities to increase value and reduce costs. Nationally, dependent eligibility audits by large employers have resulted in the identification and removal of a substantial number — an average of 10 percent — of ineligible dependents from benefits coverage.

While this audit is being conducted at the request of the Office of Internal Audit and with the approval of the Insurance Committees, the core reason to audit eligibility is to ensure accountability and, as a plan sponsor, it is simply the right thing to do to protect the plan and its members.

Before the audit begins, we wanted to provide an overview of those individuals eligible for coverage as a dependent. The following individuals are eligible for dependent coverage on your policy:

- Legally married spouse
- Natural child
- Legally adopted child
- Stepchild for whom you or your spouse has legal or joint custody or shared parenting
- Any child living in your home for whom you are the legal guardian
- Any child living in your home who you claim as a dependent on your federal income tax return

Dependent children are eligible for coverage through age 19. Dependents age 19 to 24 may only continue coverage if unmarried and either a full-time student or claimed on your federal income tax return.

Once your dependent no longer meets these eligibility guidelines, it is your responsibility to notify your agency benefits coordinator to terminate coverage. If you would like to verify the dependents currently insured under your policy, your benefits coordinator can provide you with this information as well.

The following individuals are ***not*** eligible for coverage as your dependent:

- Ex-spouse (even if court ordered)
- Parents of an employee or spouse
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

Please refer to your *Insurance Handbook* for further information on dependent eligibility. Thank you for your assistance and cooperation during this upcoming audit.

You Can Find It on the Web

Anytime you need to locate a form, brochure or handbook regarding your insurance benefits, you can find it on our website. The forms available on the site also offer the added convenience of allowing you to complete the information using your computer keyboard instead of filling them out by hand. (This does not, however, submit your information electronically. You will still need to print a copy of the form and send it to your agency benefits coordinator.) Just click on the "publications and forms" link for the information you need.

Are you thinking of retirement and wonder what the difference in your monthly premium will be? Click on the "premiums" link for detailed information.

Do you need to find a doctor or pharmacy participating in your provider's network? "Quick links" provides several direct links to popular topics for each health insurance company, including links to search for providers.

In addition to the information on our website, each of our contracted health insurance vendors provide secure sites where members can find a wide variety of information specific to their plan. While the information varies, you are generally provided with the ability to order replacement ID cards, view explanation of benefits statements or check the status of a claim.

Log-on today and see what you can find. Helpful information is just a few clicks away.

notable

Due to recent action by the Metro Planning Commission, the name of the street where our office is located has been changed from Eighth Avenue North to Rosa L. Parks Avenue. Our physical location has not changed.

Please be advised that for services to be covered under your health insurance, they must be medically necessary. Having a physical for the purpose of playing a sports event or attending camp is not a covered expense.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color or national origin. If you have a complaint regarding discrimination, please call 1.866.576.0029 or 615.741.4517.

If you are enrolled in long-term care coverage and decide to retire, you may have the premium deducted from your retirement check. Please contact MedAmerica at 1.866.615.5824 and request a "change of employment status" form. Completing this particular form will ensure a smooth process.

Cigna recently provided our office with a listing of contracted convenience clinics which are available to covered participants enrolled in either the POS option or an HMO in Nashville and Memphis. The clinics are staffed by nurse practitioners and members will be charged the standard copay for a PCP to receive services. Retail hosts include some CVS, Kroger and Walgreens locations. Please visit our website for a complete listing by clicking on "quick links" in the left hand navigation, then select the "convenience care clinics" link listed under Cigna.

Annual Enrollment Transfer Period

October 15 through November 14 is the time frame for this year's annual enrollment transfer period. You will have the opportunity to change health, dental (if available) and life (state plan only) insurance coverages during this time. Changes will be effective January 2009.

The state group insurance program does not have an open enrollment period for health coverage. Annual transfer only provides the opportunity to change your healthcare option for you and your covered dependents. For information on late applicant procedures for individuals who do not elect health coverage during their initial eligibility period, please refer to your *Insurance Handbook*.

There will be no changes in the claims administrators for any of the health or dental coverages and service areas for the POS and HMO will remain the same.

Basic Life Insurance Contract Due to Expire

State Plan — Active Employees Only

Currently, Fort Dearborn Life Insurance Company holds the contract for the provision of basic term life, accidental death and dismemberment and optional accidental death and dismemberment coverages for eligible state employees. This contract will expire at the end of calendar year 2008 and our office is in the process of issuing a request for proposals to re-procure these services for 2009. While the outcome of this procurement could result in a new vendor, plan members should not experience any change in the benefit structure. Of course, as with any procurement of this nature, a change in premium could occur.

Optional Term Life Premium to Decrease

State Plan — Active Employees Only

The initial contract for optional term and universal life coverages was set to expire at the end of June 2008. This contract allowed for a two-year renewal option contingent upon agreement in the terms between the state and Unum Group. As a result of the contract extension agreement, participants will see their monthly premium for term life coverage reduced by 9 percent effective July 1, 2008. (The table accompanying this article provides the new rates.) An additional 1 percent premium reduction will take effect July 1, 2009.

Unum is currently working on updating their member handbook and will send an updated copy to your home address as soon as they are available.

Monthly Premium Rates
Per $1,000 of Face Amount

Effective July 1, 2008

Column A Age	Column B Monthly Rate
Under 20	$ 0.049
20 – 24	$ 0.049
25 – 29	$ 0.049
30 – 34	$ 0.053
35 – 39	$ 0.067
40 – 44	$ 0.101
45 – 49	$ 0.172
50 – 54	$ 0.288
55 – 59	$ 0.449
60 – 64	$ 0.700
65 – 69	$ 1.160
70 – 74	$ 1.618
75 – 79	$ 2.486
80 and over	$ 4.493

Medicare Part D Pharmacy Plan and Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the state-sponsored healthcare options (PPO, POS and HMO) and prescription drug coverage available for people eligible for Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. This notice applies to you and your covered family members who are eligible for Medicare. **If you are actively employed, you do not need to enroll in Medicare prescription drug coverage.**

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare advantage plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The insurance committees have determined that the prescription drug coverage offered under the state-sponsored healthcare options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing state-sponsored coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving state-sponsored coverage may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your state-sponsored coverage, which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the state-sponsored healthcare options and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the state-sponsored options changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.Medicare.gov
- Call your state health insurance assistance program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1.800.Medicare (1.800.633.4227). TTY users should call 1.877.486.2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration online at www.socialsecurity.gov, or you call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Do you know the warning signs of a heart attack?

If you or someone you know is having a heart attack, the sooner you get help, the better the chances of survival. Many people hesitate to get help because they are not sure of the symptoms. But, by the time you find out for sure it's a heart attack, it may be too late.

Only sophisticated medical tests can determine if symptoms are caused by a heart attack or something else, such as digestive problems or stress. The American Heart Association and other medical experts say the body likely will send one of more of these warning signals of a heart attack:

- Uncomfortable pressure, fullness, squeezing or pain in the center of the chest lasting more than a few minutes.
- Pain spreading to the shoulders, neck or arms. The pain may be mild to intense. It may feel like pressure, tightness, burning or heavy weight. It may be located in the chest, upper abdomen, neck, jaw or inside the arms or shoulders.
- Chest discomfort with light-headedness, fainting, sweating, nausea or shortness of breath.
- Anxiety, nervousness and/or cold, sweaty skin.
- Paleness or pallor.
- Increased or irregular heart rate.

If you think someone is having a heart attack, get emergency help immediately. **The first hour after a heart attack is crucial.** While waiting, keep the person quiet and calm.

Caremark Mail Order Shipping Change

Individuals enrolled in health coverage through the state sponsored plans have access to mail order pharmacy benefits. For participants enrolled in the PPO or PPO Limited option, administered by BlueCross BlueShield, the supplier of mail order pharmaceuticals is Caremark.

To ensure the safe delivery of temperature-sensitive medicines, Caremark mail service pharmacy is changing the way certain medicines are shipped. What was previously referred to and/or handled as "seasonal cold pack" medicines will now be shipped with a method requiring a signature, instead of with a cold pack.

As of May 19, 2008, temperature-sensitive medicines shipped from Caremark mail service pharmacies to destinations with extreme temperature conditions (under 32˚ or over 85˚) are now shipped using a service that requires a signature when delivered. While occasional spikes in temperature for short periods of time will not affect most medicines, that allowable time varies by drug.

The objective is to maintain a controlled environment all the way through the delivery process to ensure adherence to the manufacturer's recommendations and eliminate any question on the safety and effectiveness of the delivered medicine.

Caremark will continue to ship medicines that must be refrigerated with an ice pack. Although medicines may have been shipped with an ice pack in the past, they may not require constant refrigeration. You should not be concerned if your orders no longer include an ice pack.

Shipping Temperature-Sensitive Medicine Features

Before Caremark ships one of these extreme temperature-sensitive medicines, their system will check the forecast temperature of the city where the medicine will be delivered.

- If it's going to be under 32˚ or over 85˚, Caremark will ship using a method that requires signature upon delivery. Once the order is shipped, you will receive a phone call from Caremark letting you know it is on the way.
- If the temperature is between 32˚ and 85˚, Caremark will ship using regular delivery.
- If no one is there to sign for the medicine, the delivery carrier will leave a note with instructions, telling you to either schedule another delivery or pick it up from the carrier.

Shipping Couriers

Caremark will generally use the U.S. Postal Service to ship temperature-sensitive medicines because, in most communities, the local post office is a convenient place to pick up a package if no one is home when it is delivered. Also, the U.S. Postal Service will re-deliver the package when asked to do so.

If the medicine is shipped using expedited delivery (at your request or at Caremark's discretion) it will be delivered by UPS or Federal Express. In this case, if no one is home when it is delivered, you will receive instructions from UPS or FedEx to schedule re-delivery or to pick up the package.

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